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ABSTRACT

While hyperactivity in children has been alternately viewed as a form of minimal brain dysfunction, as a behavior disorder, or as an attention deficit disorder, recent findings on hyperactive adolescents and adults suggest that hyperactivity can be better understood as a personality disorder. Striking similarities appear when characteristics of the male personality and the symptoms of hyperactivity, which occur in a ratio of 10 males to one female, are compared. Male traits (such as high activity level, daring, impulsivity, low impulse control, aggression, antisocial behavior, difficulties in delaying gratification, overreaction to frustration, dominance, defensiveness, and deception) in an exaggerated and maladjusted form combine with attention deficits to constitute a personality disorder. Findings of recent research indicate that symptoms of hyperactivity do not disappear in puberty. Rather, symptoms shift from academic and learning difficulties to social and self-concept problems. In comparison to matched peer-group controls, the self-image of the hyperactive adolescent has been found to be that of an inadequate person who continues to experience problems of adaptation. Most research on hyperactivity has been concerned with establishing and verifying the efficacy of different drug treatments, yet long-term follow-up studies on drug treatment show no long-term treatment effects. Additionally, no consistent and reliable evidence for the etiological theories of minimal brain damage have been verified. (Author/RH)

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HYPERACTIVITY AS A PERSONALITY DISORDER

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Abstract

The symptoms of hyperactivity are examined in relation to the personality development of male children, and subsequently viewed as maladaptive traits originating in childhood and persisting through adulthood. Etiological theories have not been verified either directly or indirectly through pharmacological or dietary treatment. Recent data show that the problems encountered in adolescence and adulthood impair social functioning and cause serious subjective distress, thereby leading to the conclusion that the disorder is more appropriately viewed as a personality disorder.

HYPERACTIVITY AS A PERSONALITY DISORDER

Hyperactivity in children has been alternately viewed as a form of minimal brain dysfunction, as a behavior disorder of childhood or adolescence or, as classified in the DSM III (1980), an Attention Deficit Disorder. Recent findings on the hyperactive in adolescence and adulthood suggest that the diagnostic entity more fittingly meets the criteria for personality disorder.

Personality disorders are considered to result from deeply ingrained maladaptive, inflexible habits or traits established early in life. When these traits are the source of significant impairment they constitute a Personality Disorder. Most personality disorders are discernible in childhood or adolescence and continue through adult life.

Studies focusing on the personality development of males and females (Block, Note 1) have shown that the sexes differ in several important ways: males are significantly more active than are females; they are more daring; are more impulsive; have more difficulty in delaying gratification; overreact to frustration and are much more likely to have behavior problems related to the control of their impulses; and are more aggressive, dominating, and antisocial. They are more defensive and deceptive, less cooperative, and less likely to form intensive social relationships.

Striking similarities appear when one compares these characteristics of the male personality and the symptoms of hyperactivity, which occur in a ratio of 10 males to 1 female: the chief characteristics of hyperactivity include impulsivity, excessive activity, inability to deal with frustration, difficulty in relating to peers, being frequently antisocial and, as will be described later, defensiveness and difficulty in engaging in satisfactory

relationships. At this point it is tempting to conclude that much of what has been described is exaggerated "maleness." I contend that these male traits in an exaggerated and maladjusted form constitute, in addition to the added dimension of attentional deficit, a personality disorder.

Early reports indicated that symptoms of hyperactivity disappear in puberty. However, recent studies have shown that these behavioral traits continue to be documented in adolescence and adulthood (Weiss, Hechtman, & Perlman, 1978; Waddell, Note 2). In adolescence and adulthood they continue to experience problems of impulsivity and distractibility; however, the focus of these problems shifts from academic and learning difficulties to social and self-concept problems. As with other personality disorders, there is an impairment in social functioning and serious subjective distress.

In a study of hyperactives in adolescence (Waddell, Note 2), hyperactives were compared to a matched control peer group on measures of self-concept and social adaptation. The hyperactives demonstrated impulsivity, recklessness, distractibility and instability. The image they have of themselves is one of little self-confidence, anticipation of failure, avoidance of social participation, possession of little discipline, and an unwillingness to face interpersonal demands. They overemphasized their worries and personal problems, lacked a sense of internalized structure and had little insight, appeared careless, rebellious, petulant and dubious about their own roles and interpersonal interactions. They were highly defensive, admitting to fewer negative things about themselves and giving fewer responses in an interview situation. Antisocial behavior continued as many of these adolescents experienced difficulty with school and legal authorities.

Hyperactive adolescents had a low level of self-esteem and saw themselves as undesirable, "bad," and inadequate, especially in reference to family and friends. They had significantly more indicators of deviancy and psychopathological disturbances.

From these data, it appears that hyperactive children in adolescence have many of the same problems they had as children. They are less socialized, have fewer interpersonal interactions, lack self-discipline and confidence, and are less steadfast and resourceful than are their peers. Their self-image is of an inadequate person, and they continue to experience problems in environmental adaptation.

The etiology of this disorder has been the subject of a great deal of varied speculation, ranging from central nervous system dysfunction, genetic abnormalities, child-rearing factors, biological predispositions, and toxicological factors, including the food additive-dietary influences on the behavior of hyperactives. None of these theories has received convincing empirical support.

The bulk of the research on hyperactivity has been concerned with establishing and verifying the efficacy of different drug treatments. Although the early results were very promising, later, more methodologically sophisticated studies failed to replicate or substantially validate them (Waddell, Note 3) and reviews (Backman & Firestone, 1979; Barkley, 1977) are not success stories. Follow-up drug studies have likewise failed to demonstrate the efficacy of drug dosage or drug treatment over time (Menkes, Rowe, & Menkes, 1967; Minde, Weiss, & Mendelson, 1972; Weiss, Kruger, Danielson, & Elman, 1975; Weiss, Minde, Werry, Douglas, & Nemath, 1971) and are further complicated because

no true controls were used. Where the medicated and non-medicated hyperactives have been compared (Waddell, Note 2), no clear therapeutic effects emerge. Many of the early myths--that stimulant drugs have a "paradoxical" effect and decrease activity level--have failed the empirical tests. While attention level has been increased by these drugs, (and this same phenomena occurs in normal children), there are no data to show that this attention increase via medication has any long-term effect on learning, academic or social. Indeed, data that would support, even though indirectly, a biological or central nervous system hypothesis have not been forthcoming.

In summary, no consistent and reliable evidence for the etiological theories of minimal brain damage or other explorations have been verified, and the long-term follow-up studies on drug treatment show no long-term treatment effects. The follow-up studies do demonstrate, however, that the symptoms persist into adolescence and adulthood and act to inhibit adequate social adaptation and the formation of a satisfactory self-concept. When the symptoms are viewed as exaggerated traits of maleness in combination with attentional problems, hyperactivity can be better understood as a personality disorder.

Reference Notes

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